MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

COMPANION GUIDE FOR THE HIPAA 837 INSTITUTIONAL ENCOUNTER VERSION 4010

July 8, 2002
Revised July 28, 2003

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional, ASC X12N 837 (004010X096)**, dated May 2000. It contains data clarifications authorized by the Department of Health and Human Services (HHS) on September 17, 2001. The clarifications include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

Encounter data submitted to the Michigan Department of Community Health (MDCH) will be handled using the 837 transaction Provider-to-Payer-to-Payer Coordination of Benefits (COB) data model. Follow the Implementation Guide instructions for COB reporting guidelines.

(The implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm.)

July 28, 2003 revisions to the Data Clarifications for the 837 Institutional Encounter, Version 4010, dated July 8, 2002 include a title change to Companion Guide for the HIPAA 837 Institutional Encounter, Version 4010.

November 22, 2002 revisions to the Data Clarifications for the 837 Institutional Encounter, Version 4010, dated July 8, 2002 include:

1. Updated Comment fields for:
    - Loop 2010BA NM109 – Subscriber Primary Identifier (Page 2)
    - Loop 2330B NM109 – Other Payer Primary Identifier (Page 5)

September 16, 2002 revisions to the Data Clarifications for the 837 Institutional Encounter, Version 4010, dated July 8, 2002 include:

1. Updated Comment fields for:
    - Loop 2000B SBR09 – Claim Filing Indicator Code (Page 2)
    - Loop 2010BA NM109 – Subscriber Primary Identifier (Page 2)
    - Loop 2320 Segment SBR – Subscriber Information (Page 4)
    - Loop 2320 SBR09 – Claim Filing Indicator Code (Page 4)
2. Added Data Element:
    - Loop 2000B SBR04 – Insured Group Name (Page 1)

Page	Loop	Segment	Data Element	Comments
59		BHT – (Header) Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use “RP” – Reporting.
60		REF – (Header) Transmission Type Identification	REF02 – Transmission Type Code	Use “004010X096” if using May 2000 Implementation Guide.
63	1000A	NM1 – Submitter Name	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH.
68	1000B	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	Use “D00111” for MDCH.
77	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM108 – Identification Code Qualifier	Use “24” or “34”.
78	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	If the provider has an assigned MDCH provider ID, the SSN or EIN reported here must correspond to that assigned ID.
83	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” unless the provider does not have a Medicaid ID, then use “0B”.
84	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF02 – Billing Provider Additional Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
99	2000B – Subscriber Hierarchical Level	HL		MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE), as recommended by the HIPAA-mandated implementation guide.
102	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	To identify MDCH’s level of responsibility use “S” if the capitated plan is the only payer (that is, patient has no other insurance), “T” if there are any other payers.
103	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR04 – Insured Group Name	Use “MICHILD” for children enrolled in the MIChild Program.

Page	Loop	Segment	Data Element	Comments
104	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Use “MC” for Medicaid, “TV” for CSHCS (Title V), “OF” (Other Federal) for MIChild, or “11” for State Medical Plan or persons who are not enrolled in Medicaid (Other Non-Federal). If recipient qualifies for more than one program, or other MDCH program not listed, use “MC”.
110	2010BA – Subscriber Name	NM1 – Subscriber Name	NM108 – Identification Code Qualifier	Use “MI”.
110	2010BA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Primary Identifier	Use the patient’s 8-digit member ID number assigned by MDCH. For MIChild enrollees use the 8-digit Client Identification Number (CIN) assigned by the enrollment broker. For other persons who are not enrolled in Medicaid or MIChild, use the patient’s Social Security Number. Use the capitated plan’s unique identifier assigned to the patient **only** when the person is not enrolled in Medicaid or MIChild and the Social Security Number is unknown.
117	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Use “SY”.
118	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF02 – Subscriber Supplemental Identifier	Use the patient’s Social Security Number. Report this value even when used in NM109 – Subscriber Primary Identifier.
127	2010BC – Payer Name	NM1 – Payer Name	NM108 – Identification Code Qualifier	Use “PI”.
128	2010BC – Payer Name	NM1 – Payer Name	NM109 – Payer Identifier	Use “D00111” for MDCH.
157	2300 – Claim	CLM		Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 CLM loop within each patient/subscriber loop.
176	2300 – Claim	CN1 – Contract Information	CN101– Contract Type Code	Use “05” when plan has a capitated arrangement with the billing provider.
208	2300 – Claim	NTE – Billing Note	NTE01 – Note Reference Code	Use “ADD”.
209	2300 – Claim	NTE – Billing Note	NTE02 Billing Note Text	Provide free-text remarks, if needed.
242	2300 – Claim	HI – Principal Procedure Information	HI01–1 – Code List Qualifier Code	Use “BR” (ICD-9-CM Principal Procedure).

Page	Loop	Segment	Data Element	Comments
242	2300 – Claim	HI – Principal Procedure Information	HI01–2 – Principal Procedure Code	See the ICD-9 CM Code book for allowable procedure codes.
244 – 255	2300 – Claim	HI – Other Procedure Information	HI0–1, HI02–1, …, HI12–1 – Code List Qualifier Code	Use “BQ” (ICD-9-CM Procedure).
245 – 255	2300 – Claim	HI – Other Procedure Information	HI01–2, HI02–2, …, HI12–2 – Procedure Code	See the ICD-9 CM Code book for allowable procedure codes.
256 – 266	2300 – Claim	HI – Occurrence Span Information	HI01–2, HI02–2, ..., HI12–2 – Occurrence Span Code	See the Michigan Uniform Billing Manual for allowable codes.
268 – 278	2300 – Claim	HI – Occurrence Information	HI01–2, HI02–2, ..., HI12–2 – Occurrence Code	See the Michigan Uniform Billing Manual for allowable codes.
281 – 291	2300 – Claim	HI – Value Information	HI01–2, HI02–2, ..., HI12–2 – Value Code	See the Michigan Uniform Billing Manual for allowable codes.
290	2300 – Claim	HI – Condition Information	HI01–2, HI02–2, ..., HI12–2 – Condition Code	See the Michigan Uniform Billing Manual for allowable codes.
326	2310A – Attending Physician Name	REF – Attending Physician Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” unless the provider does not have a Medicaid ID, then use “0B”.
327	2310A – Attending Physician Name	REF – Attending Physician Secondary Identification	REF02 – Attending Physician Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
333	2310B – Operating Physician Name	REF – Operating Physician Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” unless the provider does not have a Medicaid ID, then use “0B”.
334	2310B – Operating Physician Name	REF – Operating Physician Secondary Identification	REF02 – Operating Physician Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
340	2310C – Other Provider Name	REF – Other Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” unless the provider does not have a Medicaid ID, then use “0B”.

Page	Loop	Segment	Data Element	Comments
341	2310C – Other Provider Name	REF – Other Provider Secondary Identification	REF02 – Other Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
357	2310E – Service Facility Name	REF – Service Facility Secondary Identification	REF01 – Reference Identification Qualifier	Use "1D" unless the facility does not have a Medicaid ID.
358	2310E – Service Facility Name	REF – Service Facility Secondary Identification	REF02 – Laboratory or Facility Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID) unless the facility does not have a Medicaid ID.
359	2320 – Other Subscriber Information	SBR – Subscriber Information		This loop will be used once for the capitated plan and once for each other payer. Community Mental Health encounters will require this loop once for the Prepaid Health Plan (PHP), once for the Community Mental Health Service Program (CMHSP) Affiliate, and once for each other payer.
360	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	If the patient has Medicare or other insurance, report that coverage with code "P" or "S" as appropriate, and the capitated plan coverage with "S" or "T", as appropriate. If the patient has no other insurance, report the capitated plan coverage with "P".
361	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR02 – Individual Relationship Code	The code carried in this element is the patient's relationship to the person who is insured. For example, if a child with Medicaid has coverage under his father's insurance, use code 19 (Child).
363	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR03 – Insured Group or Policy Number	Use the subscriber's group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
363	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Community Mental Health encounters should report "MC" for Medicaid Fund and "11" (Other Non-Federal) for General Fund.
401 – 402	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM103, NM104, NM105 – Other Insured: Last Name, First Name, Middle Name	Use the name of the subscriber as it appears on the files of the capitated plan or other payer.
401 – 402	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM108 – Identification Code Qualifier	Use "MI".

Page	Loop	Segment	Data Element	Comments
403	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the capitated plan or other payer indicated in loop 2330B. For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
408	2330A – Other Subscriber Name	REF – Other Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Do not use “1W”.
411	2330B – Other Payer Name	NM1 – Other Payer Name	NM108 – Identification Code Qualifier	Use “PI”.
411	2330B – Other Payer Name	NM1 – Other Payer Name	NM109 – Other Payer Primary Identifier	For the capitated plan, use the 9-digit Payer ID assigned by MDCH. For other payers, use the 8-digit carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if BCBSM Traditional were the Other Payer, the value (carrier code) carried in this element would be “00029005”. For Medicare Part A (United Government Services) use “00452”. For Medicare Part B (Wisconsin Physician Services) use “00953”.
416	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF01 – Reference Identification Qualifier	For the capitated plan, use “F8”.
417	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF02 – Other Payer Secondary Identifier	For the capitated plan, enter the plan-assigned unique identifier (encounter reference number) for the encounter.
418	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF01 – Reference Identification Qualifier	Use “9F” or “G1”.
419	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF02 – Other Payer Prior Authorization or Referral Number	If the capitated plan or other payer pre-authorized services or a referral, enter the authorization number or referral number here. Do not use the Prior Authorization or Referral Number segment in the 2300 loop (which is specific to the destination payer).
426	2330D – Other Payer Attending Provider	REF – Other Payer Attending Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.

Page	Loop	Segment	Data Element	Comments
430	2330E – Other Payer Operating Provider	REF – Other Payer Operating Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
434	2330F – Other Payer Other Provider	REF – Other Payer Other Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
438	2330G – Other Payer Referring Provider	REF – Other Payer Referring Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
442	2330H – Other Payer Service Facility Provider	REF – Other Payer Service Facility Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
444	2400 – Service Line			The HIPAA implementation guide allows up to 999 repetitions of the 2400 service line loop for each 2300 loop.
446	2400 – Service Line	SV2 – Institutional Service Line	SV201 – Service Line Revenue Code	See the Michigan Uniform Billing Manual for allowable codes. For Community Mental Health and Substance Abuse Services, see the MDCH Crosswalk Between Service Use/Encounters Per Consumer (refer to MDCH website for HIPAA Codes for Mental Health and Substance Abuse Procedures.
447	2400 – Service Line	SV2 – Institutional Service Line	SV202-2 – Procedure Code	See the Michigan Uniform Billing Manual for allowable codes. For Community Mental Health and Substance Abuse Services, see the MDCH Crosswalk Between Service Use/Encounters Per Consumer (refer to MDCH website for HIPAA Codes for Mental Health and Substance Abuse Procedures.
490	2430 – Service Line Adjudication Information			MDCH expects this loop to be populated for each payer identified in loop 2330B that has adjudicated this claim and applied service line adjustments.